T.E.N.S

Unlimited INC.

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Durable Medical Equipment

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5145 N. Academy Blvd. Suite#210
Colorado Springs, CO 80918

PATIENT INFORMATION:

PATIENT NAME: _____ DOB: ___/___/_____ ORDER DATE: ___/___/_____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

PHONE: _____-_____-_____ EMAIL: _____ INSURANCE NAME: _____

EDD: ___/_____/_____ WKS GESTATION: _____ MEMBER ID: _____

____**STANDARD ELECTRIC BREAST PUMP (E0603)** **DX: Z39.1**

____**Hospital grade breast pump (E0604)** Length of need _____ DX: _____

Reason: _____

____ **(2 TUBING, 2 CAPS, 2 BOTTLES, 2 BREAST SHIELDS, 6 VALVES/MEMBRANES, MILK BAGS)**

___ Post-partum garment (L2640) QTY: ____ Size: XS SM M L XL 2XL DX: M62.08

___ Compression socks (A6531) QTY: ___ Size: XS SM M L XL 2XL DX: R60.9

___ Pelvic support brace (L0621) Size: XS SM M L XL 2XL DX: R10.2

___Prenatal Cradle (V-sling) (L8310) QTY: ___ Size: XS SM M L XL DX: O22.00

___C- Section Kits (QTY ____ A6212 QTY_____ A5245) DX: O90.0

___Other: Please specify: _____ **DX:** _____

I certify that I am the physician identified in this form. I have reviewed the detailed written order. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. ***I will provide medical documentation to help with the DME processing.*** I acknowledge that the patient is aware that **DME** may contact them for any additional information to process this order. A copy of this order will be retained as a part of the patient's medical record.

REQUESTING PHYSICIAN INFORMATION

Physicians Name: _____ NPI: _____

Signature: _____ Signed Date: _____/_____/_____

Contact Phone: _____-_____-_____ Contact Fax: _____-_____-_____

Address: _____ City: _____ State/Zip: _____